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Suicide in General Hospitals

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Of 14 medical and surgical patients who committed suicide in a general hospital, there were ten men and four women, ranging in age from 19 to 82. The patients had not made statements of suicidal intent; however, their hospital records showed there had been symptoms of depression and contained indirect references to a preoccupation with suicide. Most of the patients had been depressed because of their illnesses or distressing symptoms.

It is important to keep in mind that there are clues that help anticipate suicide. Awareness by hospital staffs of symptoms and subtle signs of depression and of suicidal thoughts in patients is important in reducing the number of suicides in general hospitals. Of preventive and treatment measures, warmth, compassion and commitment to the care of patients by hospital staffs are most important.

WHEN A PATIENT in a general hospital commits suicide, there generally has been a failure by the staff to see signs or symptoms of depression, and therefore a failure to institute preventive measures. In patients who have not shown signs of depression or suicidal intent, recognizing this intent is especially difficult and members of the hospital staff should be aware of indications of psychiatric illness. Because there have been relatively few studies of suicide in medical and surgical departments, other than that by Pollack,[1] further analysis of the problem is needed.

During a ten-year period in a general hospital where a high percentage of the patients in other departments were referred to the psychiatric liaison department,[2] 14 medical or surgical patients with whom consultations had not been requested killed themselves. More than a fourth of the patients (150) seen in consultation for psychiatric problems were found to be depressed.[3] However, none of them committed suicide. Collaborative treatment by the medical and surgical staff and the psychiatric consultant was carried out in all patients, except in 12 who were transferred to the psychiatry department.

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Methods and Symptoms

Among the 14 patients not seen by a psychiatrist, 12 jumped from windows, one cut his throat and another stabbed himself. (Of Pollack's 11 patients, ten jumped from windows and one cut his throat.[1]) There were ten men and four women, aged 19 to 82, with widely varying illnesses. Four patients had malignant conditions with unfavorable prognoses and three had other terminal illnesses. In seven patients the prognosis was considered *fair* to *excellent* for recovery; of these, two had cardiovascular disease and the other five had peptic ulcer, hyperthyroidism, sciatica, acute cholecystitis or fractures from an

automobile accident. During the ten years one patient in the psychiatric department committed suicide by hanging.

The hospital records of the patients who committed suicide contained notes made by physicians or nurses showing some evidence of depression in each case: "The patient has become apathetic. He seems to have lost the desire to get well." "He is waking up early and seems worse in the morning than the evening." "There is no desire for food." Direct or indirect communication of suicidal preoccupation was illustrated by such remarks from patients as "I cannot bear this pain much longer," "I'm never going to get well," "I won't be here tomorrow" or "I have lived long enough."

Clinical Syndromes

Psychiatric diagnoses were not clear in some cases, but it seemed from the information available that most of the patients had neuroses resulting from: (1) serious or even fatal illnesses, (2) delusions of having an illness with a poor prognosis, (3) distress because of pain, nausea, vomiting, respiratory difficulties, and disabilities of movement or (4) fear of suffering or death. Three patients showed symptoms of such a mild degree of psychotic depression that diagnosis was uncertain. In two patients some clouding of the sensorium indicated an organic brain syndrome caused by a toxic or structural condition. These findings contrast those of Pollack[1] who analyzed the clinical records of 11 men, medical and surgical patients, who committed suicide in a Veterans Administration teaching hospital. He concluded that seven of the patients had unrecognized organic psychoses and two of the patients had functional, or possibly functional, depressive psychoses. The presumed cause of suicide in another patient was a reaction to extreme pain and physical disability, and the presumed cause in the 11th patient was depression resulting from physical disease in an emotionally unstable, anxious personality.

Danger Signals

In a previous report[4] the evaluation and management of suicidal behavior has been discussed in some detail. Physicians, nurses, aides and social workers on a ward should recognize the danger signals often preceding suicidal behavior. The staff's vigilance can help prevent suicides by making it possible to institute immediate precautionary measures, treatment and psychiatric consultation.

Because some degree of depression (varying from a mood of depression to a neurotic reactive depressive illness to a severe depressive psychosis) is present in a high percentage of those patients with suicidal behavior (ranging from suicidal gestures to actual suicide), it is important to be aware of the common symptoms of a depressive reaction. The more severe the depression, the more likely a patient is to complete the act. The most common emotional and cognitive manifestations of depression are sadness, self-depreciation, hopelessness, crying, diurnal mood variation, decreased libido, indecisiveness, poor concentration, suicidal preoccupation, apathy, and hypochondriasis or even somatic delusions. In the most severe depressive illnesses, delusions of worthlessness, sinfulness or poverty, and auditory hallucinations of condemnation may occur. The most common physical manifestations of depression are pain, insomnia, fatigability, anorexia, weight changes, constipation, psychomotor retardation or agitation, and lowered metabolism. In adolescents, boredom, difficulty in concentrating, fatigue, insomnia and hypochondriasis are frequent symptoms of depression.[5] Often only some of the symptoms are present.

In some patients there may be underlying depression with no affective symptoms, but with complaints of weight loss, insomnia and pain—which can often be equivalents of depression. The nature of such a masked depressive illness has been confirmed by favorable responses in such cases to therapy with antidepressant medications or electroshock treatments. It should be emphasized that just as symptoms of depression may mask organic disease, physical symptoms of disease may mask depression.[6]

Other Clues

In addition to indirect references to suicide and the symptoms of depression, there are other valuable clues to potential suicides. Disoriented patients may respond to delusional or hallucinatory commands to kill themselves. Patients who are irritable, demanding or uncooperative, frequently have underlying hostility toward themselves, which may lead to suicidal action. These patients tend to alienate the staff but frequently respond well to extra attention. When suicidal ideas are suspected, gentle and tactful questioning may bring out suicidal ideation. Talking about suicide is apt to decrease rather than increase the risk of suicide by giving a patient an opportunity to discuss his

thoughts and feelings with a confidant. Patients who have had close friends or relatives die, or who have lost status, health, money, physical appearance or function, are especially susceptible to suicidal behavior. In previous studies of suicides and attempted suicides,[7,8] loss of health was shown to be a frequent cause, surpassed only by loss of loved ones.[9] Previous attempted suicides are indications of a higher risk.

High-Risk Groups

Although there is no substitute for knowing a patient well, data based on probability are valuable in considering suicidal risk. The highest incidence of suicide occurs in the following categories: men; people who are divorced, separated or widowed; drug abusers or excessive users of alcohol; unemployed persons; those with poor living conditions; persons who are physically or psychiatrically ill; members of the white race, and those in the older groups. However, in recent years growing numbers of young people have committed suicide; for those between ages 15 and 24, the rate rose between 1957 and 1975 from 4.0 to 10.5 suicides per 100,000.

Precautions

A number of precautions should be carried out. Because many suicides in hospitals are committed by patients jumping from windows, safety screens should be used. Sharp objects, such as knives, blades and glass, and material that could be used for hanging oneself, such as ropes, neckties and belts, should be removed. Patients should be checked frequently and receive solicitous attention from nursing personnel. A few patients will need the protection and treatment provided by a psychiatric department.

Treatment

The main approaches to treatment are psychotherapy, electroshock, and administration of antidepressant and tranquilizing drugs. Use of electroshock treatment should be reserved for those in whom other types of therapy are not effective.

Psychiatric consultation should be requested for patients suspected of having suicidal thoughts, those who have already expressed them, and those who have made suicide attempts—even though the attempts do not seem serious. With suggestions from a psychiatrist the concerned family physician can best care for most suicidal general hospital patients. Patients with severe psychotic depressions, and those needing intensive personality analysis or electroshock therapy, should be treated by a psychiatrist. Appropriate medications can be prescribed by a physician who is familiar with the patient's behavior.

Crucial to preventing suicidal behavior is the dedication of nurses, social workers, and physicians during the patients' hospital stay. Constructive, sustaining relationships may be developed with people in any of these professional categories.

After a patient's discharge from the hospital, the physician needs to be available for phone calls, even in the middle of the night, and frequent, even daily visits, as long as the danger of suicide exists. The patient should be allowed to express his feelings without dwelling on morbid ideas, and he should be reassured that based on our knowledge the prognosis for depressive illnesses is excellent. Physicians should suggest that a depressed patient use recreational and occupational diversions geared to the patient's ability to concentrate.

For a depressed patient, the loss of the patient-physician relationship, or a threat of losing it, may be the final trauma leading to suicidal behavior. Because treating depressed patients is likely to be stressful and wearing, a physician should not become involved if he does not wish to treat the patient, or does not feel he can devote sufficient time. If a practitioner does not assume responsibility for treatment of a suicidal patient, he can refer the patient to a psychiatrist or to a mental health, suicide prevention or crisis clinic. If he does assume responsibility for treatment, he must offer all the resourcefulness and dedication he would give in any other life-and-death situation. For most patients the practitioner's credentials or expertise matter less than does his capacity for warmth, compassion and emotional commitment.

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